DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Child Development Watch

DATE:
REFERRAL TO:
SERVICE REQUESTED: **THERAPY:** ☐ OT ☐ PT ☐ SLP ☐ ECE
EVALUATION: ☐ OT ☐ PT ☐ SLP ☐ ECE/Carolina ☐ ECE/BSID III
OTHER:

RBI Needed ☐ Yes **Preferred Discipline:** ☐ No
RBI Scheduled ☐ Yes **Date**: ☐ No
RBI Completed ☐ Yes **Date**: **Provider**: ☐ No

IS PROVIDER EVALUATION NEEDED TO HELP CDW DETERMINE PART C ELIGIBILITY? ☐***YES*** ☐***NO***

Child's Name: Birthdate: Medicaid/DHSS Cares #

Client's Address: Home Phone #:

County: Sex: ☐Male ☐ Female Child's Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino
Child's Race (CHECK ALL THAT APPLY): ☐White ☐Black or African American ☐Asian
☐American Indian or Alaska Native ☐Native Hawaiian or Other Pacific Islander

IS THIS AN ADD-ON SERVICE WITH CURRENT PROVIDER? ☐YES ☐NO - **IF "NO", COMPLETE ↓**
PARENTAL CONSENT DATE FROM AUTHO FORM ALLOWING CDW TO RELEASE RECORDS:

- **PROVIDER – PLEASE REQUEST RX FROM PCP ☐YES ☐NO, Rx is attached or pending**

School District	Primary Language
Mother's Name MCI#	Birth Date Email
Address	Phone #(H) (CELL) (W)
Father's Name	Birth Date Email
Address (if different than client's)	Phone #(H) (CELL) (W)
Guardian/Foster Parent/Educational Surrogate Name	
Address Phone #(H) (CELL) (W)	
Child Care Name Address Phone#	
Birth Weight Current Weight	Gestation (weeks) APGARS
Primary Physician	Phone # Fax #
☐Private Insurance - Name: Insurance Phone#: Insurance Address: *IF DELAWARE MEDICAID ONLY - CHECK BELOW:* ☐*MA-FFS* ☐*MA-Highmark Health Options* ☐*MA-United Healthcare*	Policy Holder: ☐Mom ☐Dad *(MUST include DOB above)* Employer: Group/Acct # Child's ID# Plan Type: ☐PPO ☐EPO ☐POS ☐HMO ☐IPA ☐HSA** ☐Other
****IF FAMILY HAS HSA PLAN, THEY MUST STOP AUTOMATIC WITHDRAWALS FROM THE ACCOUNT.**** Insurance Comments:	
REFERRING AGENCY/PERSON Phone # Email:	

ICD10 ____ ____ ____ ____

History: